Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL DALLAS
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Carrier's Austin Representative Box
#01

MFDR Date Received
NOVEMBER 14, 2007

Respondent Name
VANLINER INSURANCE CO

MFDR Tracking Number
M4-08-1910-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated November 9, 2007: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)…Per the stop-loss method the carrier should have reimbursed the provider $44,870.08."

Requestor's Supplemental Position Summary Dated October 2, 2011: "1. **The Audited charges of $59,826.77 for [Claimant's] hospital inpatient admission exceeds the $40,000 stop-loss threshold**. 2. **The services rendered to [Claimant] were unusually costly and extensive**…because:

- [**Claimant] underwent multiple surgeries**. [Claimants'] hospital stay involved multiple surgical procedures performed by two surgeons, which included an anterior re-exploration; the removal of hardware, plate and screws; and the re-fusion of C4-C5 and C5-C6 with replacement of hardware as well as bone grafting.
- [**Claimant] suffered complications**. After his surgeries [Claimant] was transferred to the ICU for observation, he experienced discomfort and difficulty speaking. The hospital preauthorized an additional day for [Claimants'] admission to allow for further observation and more time to heal. Additionally, [Claimants'] admission was complicated by the presence of bacteria and white blood cells in his urine.
- **The cost of the admission as outside of the ordinary**. [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2007 was $39,766.32. The average amount billed for hospital inpatient admissions with Principal Diagnosis Code (996.49) and Principal Procedure Code (03.09) in 2007 was $20,771.37. The charge for [Claimant's] admission was $59,826.77. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2007.
- **The costs were front-loaded**. The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment… For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Amount in Dispute: $44,870.08

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated December 3, 2007: "Allowing hospitals to set their own charges for implantables and supplies, and then removing insurance carrier's abilities to audit charges thereby forcing them to pay inflated bills, leads to absurd results and does not achieve effective cost control."

Respondent's Supplemental Position Summary Dated October 11, 2011: "Renaissance Hospital did not demonstrate that the services provided which were provided to the claimant were unusually costly and unusually extensive to warrant eligibility for stop loss reimbursement. In summation, The only thing unusually costly and unusually extensive about Renaissance Hospital's treatment and charges was the exorbitant amount which they charged for this normal operative theater and in patient stay. Allowing hospitals to set their own charges for implantables and supplies, and then removing insurance carrier's abilities to audit charges thereby forcing them to pay inflated bills, leads to absurd results and does not achieve effective cost control."

Responses Submitted by: Workers' Compensation & 'CARF' Consultants for Vanliner Insurance Company

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 23, 2007 through May 25, 2007	Inpatient Hospital Services	$44,870.08	$1,560.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.
4. Texas Labor Code §417.002, effective September 1, 1993, addresses recovery in third-party action.
5. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for non-emergency inpatient hospitalizations.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
- 45 – Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07; Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
- 46 – Item: Itemized statement is required to evaluate billed charges (professional review).
- 855-002 – Recommended allowance is in accordance with workers compensation medical fee schedule guidelines.
- 855-024 – Service is denied for lack of proof of pre-authorization.
- 886-912 – Item: Itemized statement is required to evaluate billed charges (professional review).
- 900-021 – Any network reduction is in accordance with the network referenced above.
- W1 – Workers Compensation State Fee Schedule Adjustment.
- W1 – State Fee Schedule
- 198 – Services exceed preauthorization.
- W6 – Reduction/denial based on a subrogation of a third party settlement 100%.

U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE

THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Does a Third Party Settlement issue exist in this dispute?
2. Does the documentation support that a contractual agreement issue exist in this dispute?
3. Does a preauthorization issue exist in this dispute?
4. Did the audited charges exceed $40,000.00?
5. Did the admission in dispute involve unusually extensive services?
6. Did the admission in dispute involve unusually costly services?
7. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. According to the explanation of benefits, the respondent denied/reduced payment based upon reason code "W6."

   Texas Labor Code §417.002(a) states "The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury."

   The respondent states in the position summary that "In October 2006, the claimant…settled a third party claim that arose from the claimant's accident. Vanliner Insurance Company received a credit of $15,000.00 as that amount received by the claimant. Renaissance Hospital submitted their bill for the 05/23/07 through 05/25/07 dates of service in the amount of $59,826.77. At the time of the audit the carrier's credit stood at $6,733.02, as bills had been audited in the amount of $8,266.98 between the date of settlement and the audit of this bill, 7/19/07. The action taken by Vanliner Insurance Company in this case, is in direct compliance with §417.002.

   The respondent did not submit documentation to support the position that a credit remained or the denial reason code of "W6". The Division finds insufficient documentation to support the third party settlement issue

in this dispute; therefore, the disputed services will be reviewed in accordance with Division rules and guidelines.

2. According to the explanation of benefits, the carrier paid the services in dispute in accordance with a contracted or legislated fee arrangement. The "PPO DISCOUNT" amount on the submitted explanation of benefits denotes a "0.00" discount. The Division finds that documentation does not support that the services were discounted due to a contract; therefore, reimbursement for the services will be reviewed in accordance with applicable Division rules and guidelines

3. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason codes "855-024 and 198".

   28 Texas Administrative Code §134.600(p)(1) states "Non-emergency health care requiring preauthorization includes: inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

   28 Texas Administrative Code §134.600(q)(1) states "The health care requiring concurrent review for an extension for previously approved services includes: inpatient length of stay."

   The respondent states in the position summary that "On May 1, 2007, Renaissance Hospital obtained express written preauthorization for, 'Exploration hardware removal w/re-fusion C4-5, 1 Day inpatient stay.' On May 29, 2007, Renaissance Hospital obtained express written preauthorization for, 'Add'l 1 Day stay May 24, 2007'."

   The respondent supports that the requestor obtained preauthorization approval for a two day inpatient stay. The disputed services are for a two day inpatient stay; therefore, the insurance carrier's denial based upon reason codes "855-024 and 198" are not supported.

4. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $59,826.77. The Division concludes that the total audited charges exceed $40,000.

5. In its original position statement, the requestor asserts that "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)." 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." The requestor's original position statement failed to discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that "The services rendered to [Claimant] were unusually costly and extensive…because: [Claimant] underwent multiple surgeries. [Claimant] suffered complications." The requestor's position that this admission is unusually extensive due to surgical procedures and complications fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries or admissions.

   The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

6. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

   > The cost of the admission as outside of the ordinary. [Claimant's] hospital admission was outside of the ordinary because the cost of the services for this admission when compared to the results of a statistical survey of system-wide data maintained by the Division for hospital inpatient admissions in Texas exceeded the norm. The average amount billed for hospital inpatient admissions system-wide in the State of Texas in 2007 was $39,766.32. The average amount billed for hospital inpatient

admissions with Principal Diagnosis Code (996.49) and Principal Procedure Code (03.09) in 2007 was $20,771.37. The charge for [Claimant's] admission was $59,826.77. [Claimant's] hospital admission was outside of the ordinary because the amount billed was greater than the system-wide average for 2007.

The division notes that the audited charges of $59,826.77 are discussed above as a separate and distinct factor pursuant to 28 Texas Administrative Code §134.401(c)(6)(A)(i). The requestor asserts that because the amount ***billed charges*** exceeds the average for the same principal diagnosis and procedure codes, the ***cost*** of the services is therefore "out of the ordinary." Although the requestor lists and quantifies ***billing*** data, the requestor fails to list or quantify the ***costs*** associated with the disputed services. In the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276, the division concluded that "hospital charges are not a valid indicator of a hospital's costs of providing services."

The requestor further states:

> The costs were front-loaded**.** The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

7. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were ICU; therefore, the standard per diem amount of $1,560.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days; however, the requestor only billed for one day in ICU. The ICU per diem rate of $1,560.00 multiplied by the length of stay of one day results in an allowable amount of $1,560.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $29,439.47. The medical documentation provided finds that although the requestor submitted purchase orders to support what the requestor was charged by the supplier for the implantables, there was no documentation found to support the amounts that the requestor paid for the implantables. The division finds that the cost to the hospital for the implantables billed under revenue code 278 cannot be established; therefore no reimbursement can be recommended for these items.

The division concludes that the total allowable for this admission is $1,560.00. The respondent paid $0.00. Based upon the documentation submitted, reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $1,560.00 additional reimbursement for the services in dispute.

Authorized Signature

		3/21/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.